

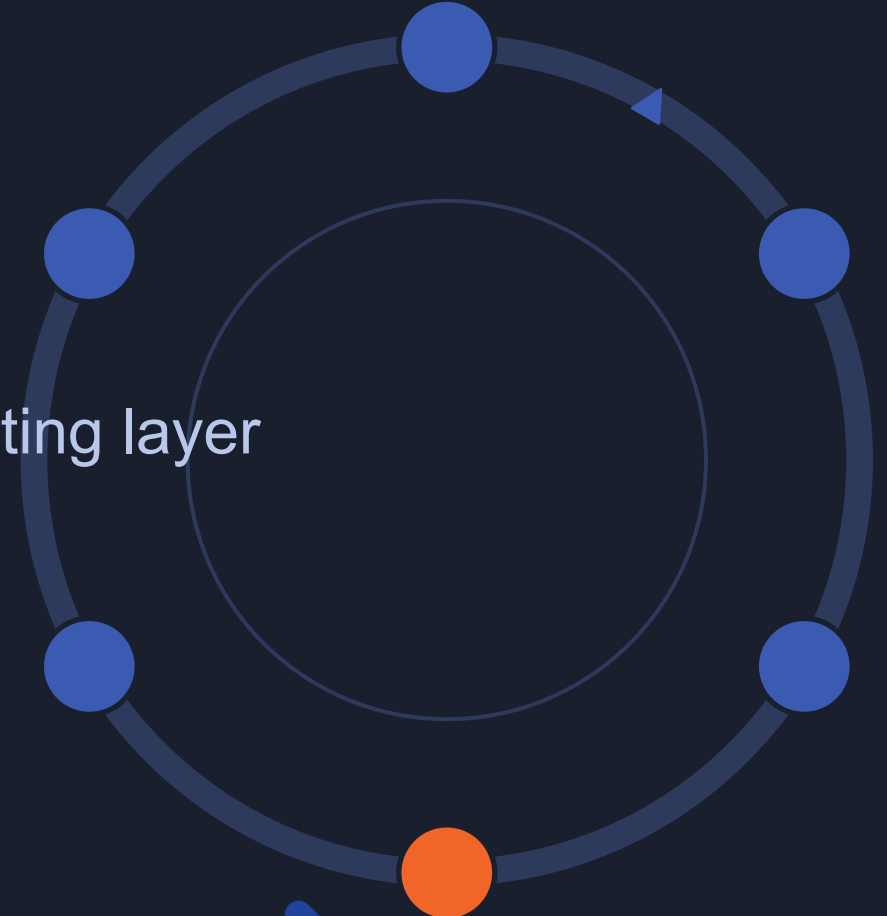


The Future Operating Model for Value-Based Care

Why the next-generation ACO needs an AI operating layer

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WELCOME

From one workflow, to one ACO, to the operating model



WEBINAR 1 · MARCH 2026

Automation with Accountability

Scaling patient engagement without burning out teams

WEBINAR 2

Palm Beach ACO in practice

A real-world closed-loop use case

TODAY

The operating model

What has to be true across the whole ACO as AI becomes part of how care gets executed

TODAY'S AGENDA

- 01 Why the operating model must change
- 02 What an AI operating layer is
- 03 Five domains of execution
- 04 Humans in the loop, governance, measurement
- 05 Roadmap, Q&A



Risk is rising faster than execution capacity

82.8%

of MSSP ACOs are in Level E or ENHANCED

CMS, Feb 2026

12.6M

beneficiaries assigned to MSSP ACOs

CMS, as of Jan 1, 2026

\$2.5B

net Medicare savings in PY2024

CMS, Sept 2025

WHAT CHANGES NEXT



JUL 2026

ACCESS launched

Outcome-aligned payments for chronic conditions



SEP 14, 2026

CY2027 comments close

BASIC E sharing 50→60% · APP
Plus trimmed to 8 measures · **RFI**
on **AI-augmented AWVs**



DEC 31, 2026

ACO REACH ends



JAN 1, 2027

LEAD begins

10-year model, no rebasing; AI-inferred risk adjustment planned

More risk, longer horizons, outcome-tied payment — and the same care teams.



ACOs don't have a knowing problem. They have a doing problem.

What most ACOs already have

- Claims analytics and cost reports
- Quality dashboards and gap lists
- Risk stratification scores
- HCC suspect and recapture reports
- ADT and discharge feeds

THE EXECUTION GAP



What actually moves results

- Patient reached
- Visit kept
- Gap closed
- Condition documented
- Escalation handled

The operating model decides what happens next.

Follow-through is where value-based care leaks

National figures — none of them are knowledge problems



11.3%

of eligible Medicare discharges received transitional care management

JAMA Health Forum, 2024

38%

had a primary care visit within 14 days of discharge

Same study

~40%

of Medicare FFS beneficiaries get an Annual Wellness Visit in a given year;

Wakely, Dec 2025

<4%

of eligible beneficiaries receive chronic care management

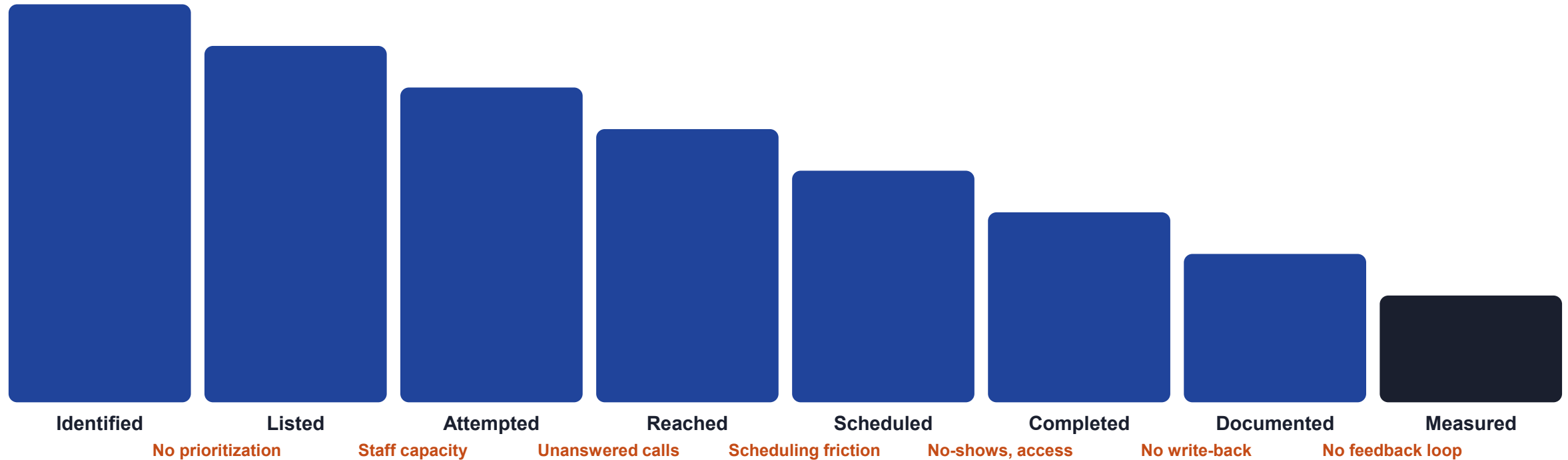
Avalere, 2025



Work is created faster than it can be closed

Every handoff leaks — and nobody owns the loop end to end (illustrative)

Patients lost at each handoff



Where does your funnel leak the most?

Poll 1

Answer one or more choices



Where does execution break down most in your ACO today?



Reaching patients



Scheduling and no-shows

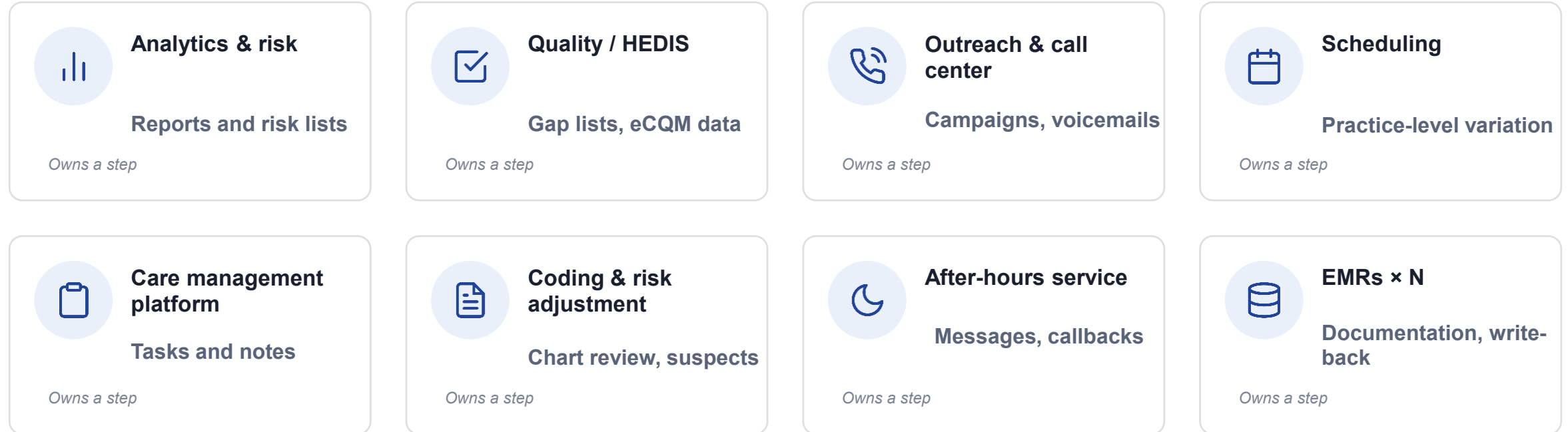


Care-gap and care-plan follow-through



Documentation and EMR write-back

Point solutions optimize steps. Nobody owns the loop.



39% of ACOs run more than ten EHR systems
NAACOS survey, 2022

75% of VBC leaders cite lack of interoperability as a top barrier
NAACOS + Innovaccer, 2025

The missing element is not another tile. It is a layer whose job is closure.

What an AI operating layer is

The connective tissue between insights and outcome.

It takes signals from the data you already have, decides who needs what, engages the patient, routes the work to the right person or system, writes the result back, and measures closure — with people in the loop by design.



Not another dashboard

A dashboard reports. The layer creates the next action and finishes it.



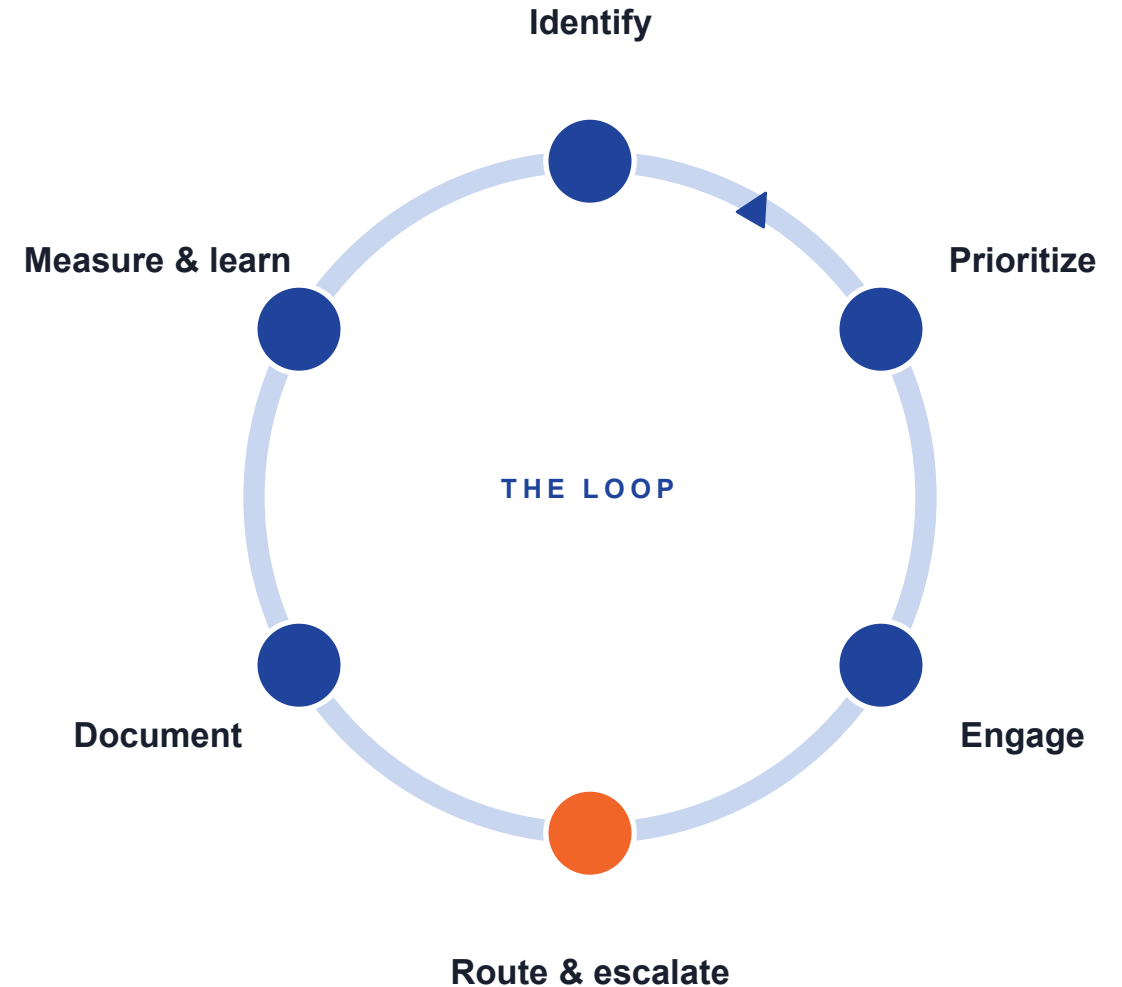
Not an EHR replacement

It works around the EMRs you have and writes back into them.



Not autonomous medicine

Structured work is automated. Judgment, decisions, and relationships stay human.



An operating model is more than a technology layer

Five things the next-generation ACOs has to decide —



Workflows

Which loops you run
— each with an explicit
definition of closure



Roles

What AI does, what
care teams do, what
clinicians decide



Decision rights

When a human must
be in the loop —
who, and how fast



Technology & data

The layer, its
integrations, and
write-back into the
EMR

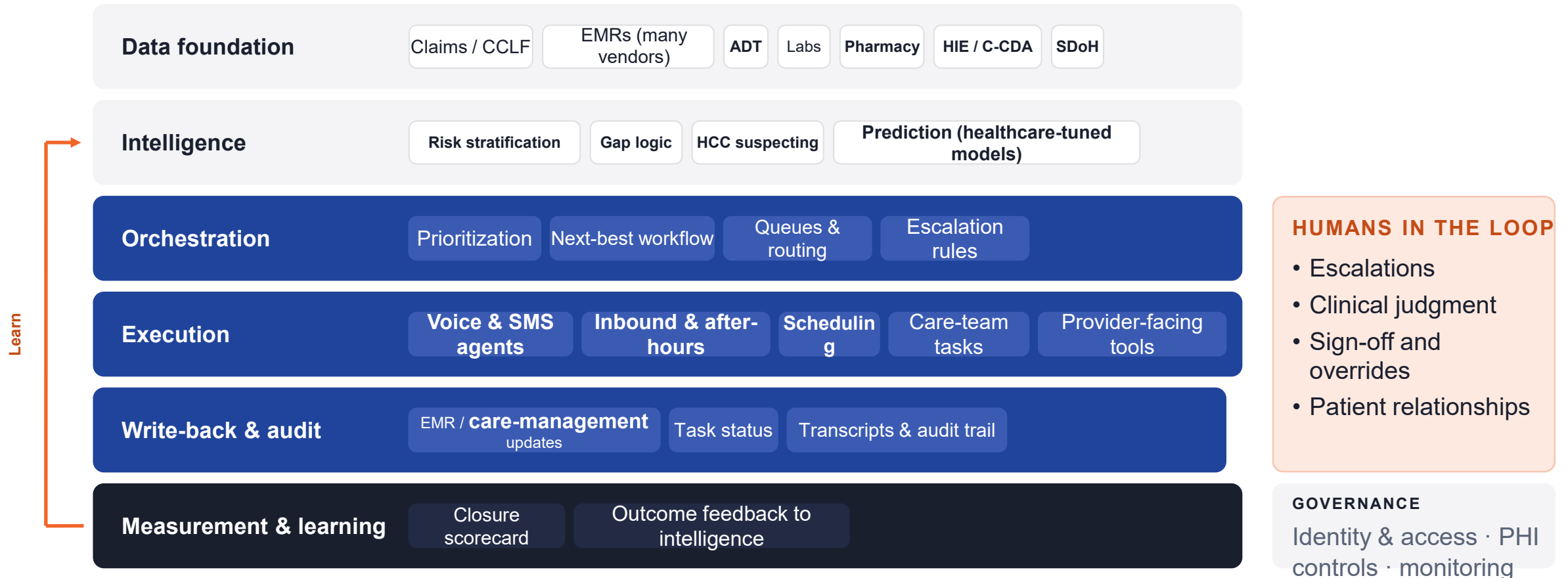


Measurement

Closure and
outcomes — not
activity

The layer is the enabler. The operating model is the commitment.

Reference architecture: from signal to closed loop



One architecture underneath every workflow — not one integration per use case.



Build the backbone once. Deploy it many times.

Different triggers, same execution logic — and a written definition of closure for each

WORKFLOW	TRIGGER	CLOSURE MEANS
Post-discharge (TCM)	ADT discharge event	Reached within 48 hours; follow-up visit kept within 7–14 days
Annual Wellness Visit	Eligible or due	AWV completed and documented
Quality gap (e.g., colorectal screening)	Open measure gap	Screening resulted and documented
Rising risk or abnormal result	Lab or utilization signal	Care plan updated; clinician reviewed
After-hours call	Inbound call	Resolved or escalated; next-day follow-up completed
Suspected condition (HCC)	Claims, labs, notes	Assessed and documented — or ruled out — at the visit

Write the closure column first. Everything else follows from it.

Poll 2

Answer one or more choices.



Which capabilities would move your ACO the most in the next 12 months?



Prioritization and prediction



Automated outreach and scheduling



Closed-loop care management and gap closure



Provider-facing tools (ambient documentation, pre-visit brief)

Five domains, one loop

The same backbone underneath each — different triggers, actors, and closure definitions



Identify & prioritize:



The question changes from "who is on the list?" to "who needs action now — through which workflow?"

● The layer handles

- Combines claims, ADT, gaps, labs
- Ranks by impact and urgency
- Chooses the workflow
- Attaches a closure definition

● People own

- high-risk cohorts
- clinical overrides
- feedback that retrain priorities

● Closure means

Every prioritized patient sits in a queue with an owner, a next action, and a due date.

FROM REACTIVE TO PREDICTIVE

Reactive

Discharge → outreach

Proactive

Rising risk → care-manager queue

Predictive

Progression risk → prevention workflow

EMERGING

Engage & schedule: reach is the first mile, not the finish line

Has to be wired to the next action



● The layer handles

- Voice, SMS
- Timing, retries, and confirmations
- Scheduling, rescheduling, no-shows
- Structured assessments by protocol

● People own

- Red-flag symptoms
- Complex questions
- The relationship

● Closure means

Appointment kept or care completed and documented. Not "attempts made."



Care management & quality closure: close the gap, not the ticket

● The layer handles

- TCM and CCM touchpoints
- Medication and refill follow-up
- Screening and lab reminders, with scheduling
- Referral tracking and care-plan task creation

● People own

- Assessments and care plans
- Clinical judgment
- Escalations and complex cases

● Closure means

The measure numerator is met and documented — A1c resulted, BP rechecked, screening completed, follow-up plan on file.

Risk & HCC capture: document what is true



The layer handles

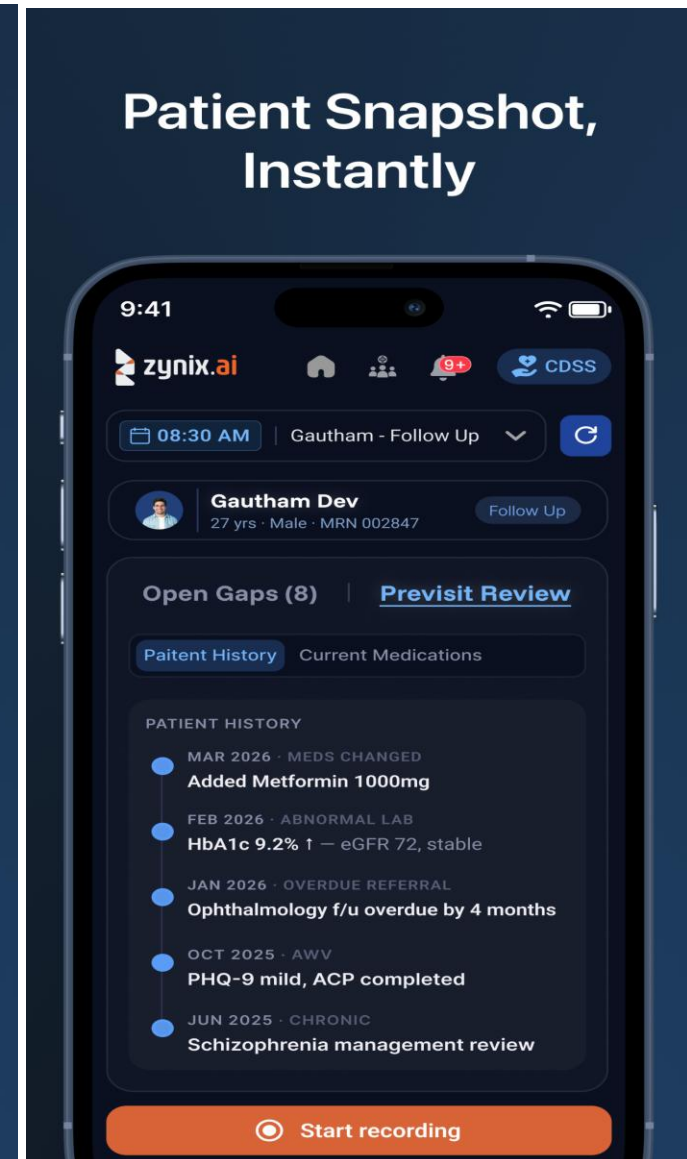
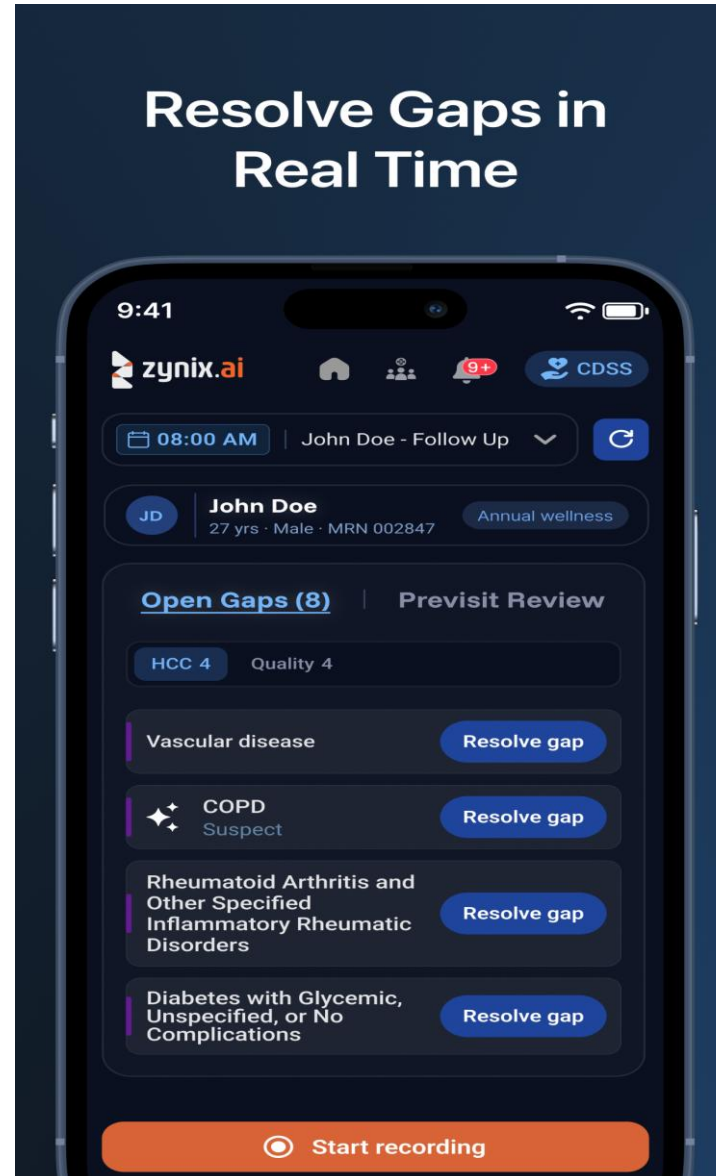
Suspect and recapture
Pre-visit brief and
AWV scheduling

People own

Clinical assessment

Closure means

Condition assessed and
documented





Provider-facing workflow: the visit becomes the trigger

● The layer handles

- Ambient documentation
- Pre-visit brief: open gaps, suspects, recent utilization
- Draft orders and referrals
- Post-visit routing of care-gap and follow-up tasks

● People own

- The visit
- Note review and sign-off
- Every clinical decision

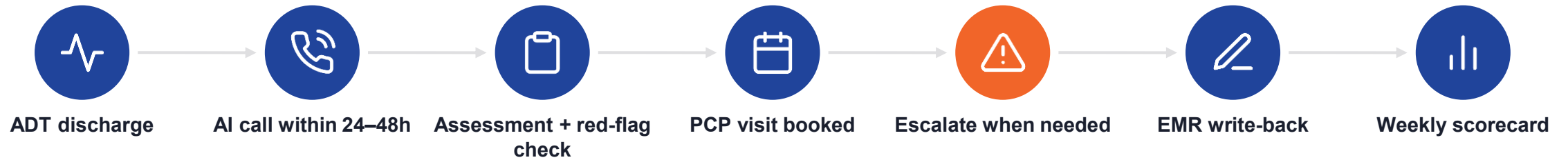
● Closure means

Note signed; downstream tasks created and owned.



What it looks like when the loop closes

Post-discharge follow-up in a Florida MSSP ACO — the workflow behind our previous webinar



45-65%

post-discharge contact rate

20% more

Annual Wellness Visit completion

30+

EMR types integrated



Autonomy is tiered by risk- by design, not by exception

More human judgment →

TIER 1

Administrative

Scheduling · reminders · logistics ·
confirmations

AI acts. Periodic audit.

TIER 2

Clinical information

Symptom check-ins · medication questions
· post-discharge assessments

**AI engages by protocol.
Triggers escalate to licensed
staff within a target time.**

TIER 3

Clinical decisions

Diagnosis · treatment changes · care plans
· coding sign-off

**Humans decide. AI prepares the
context and the draft.**

Govern it like a clinical program



What the environment now expects

- **Joint Commission + CHAI guidance (Sept 2025):** governance, transparency, data use, risk-tiered monitoring, safety-event reporting, bias assessment, training — certification launched June 2026
- **CMS CY2027 proposal: a MIPS improvement activity on responsible AI use** — fairness, appropriateness, validity, effectiveness

Operating controls for your ACO

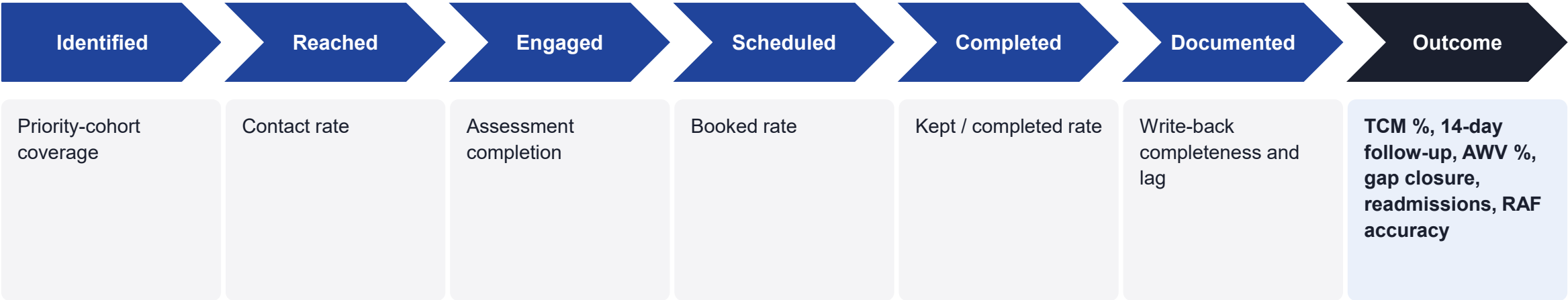
- AI governance committee: clinical, compliance, IT, and patient representation
- Vendor model cards, and bias testing on your population
- Monitoring cadence tiered by risk — clinical tools checked more often than administrative ones
- Safety-event reporting, treated like any patient-safety event
- Audit logs and transcripts for every interaction
- Patient disclosure, consent for voice outreach, and a path to a human
- Role-specific training for care teams and clinicians

Ask every vendor to evidence the right-hand column. Ask yourself whether you could.



If you can't see the loop, you can't manage it

The closed-loop scorecard: one row per stage, reviewed weekly



STAGE CONVERSION — WHERE THE LOOP LEAKS

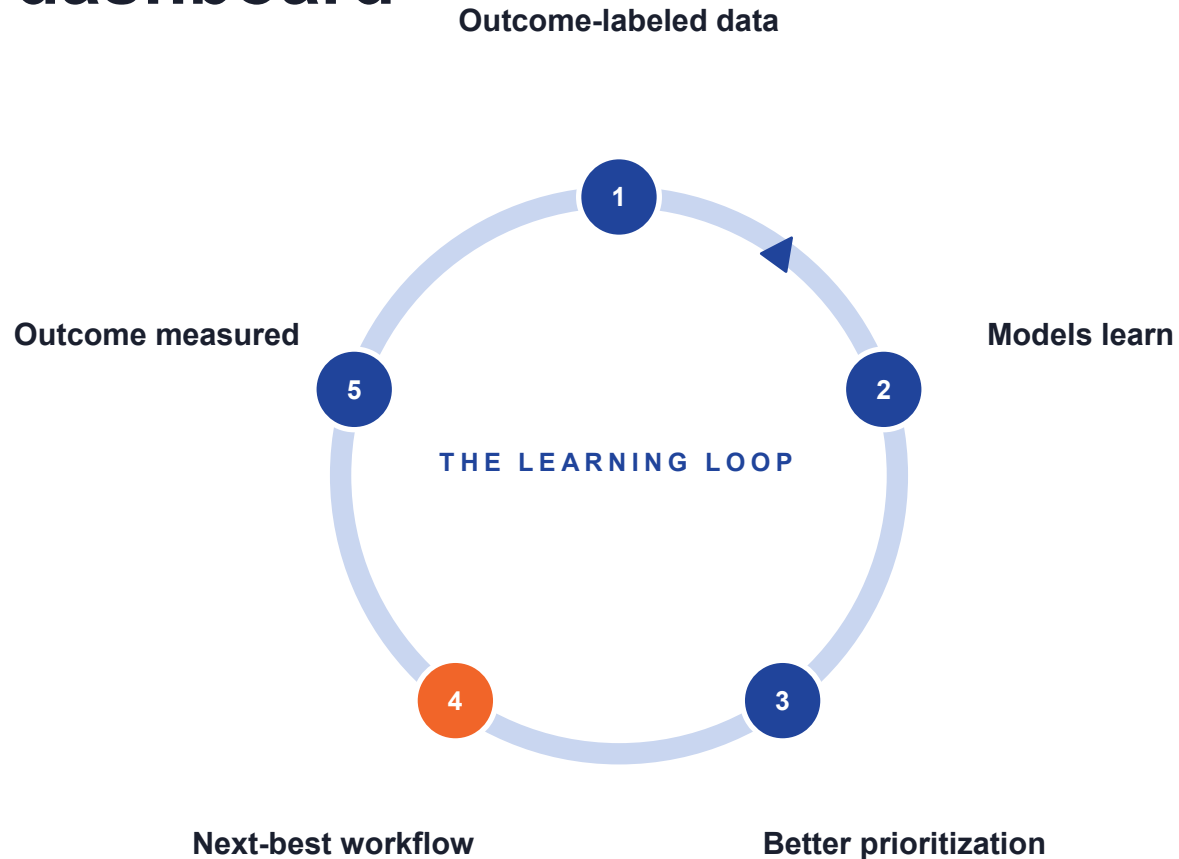
TRUST METRICS — RUN ALONGSIDE

- Escalation rate and response time
- Opt-outs and complaints
- Accuracy and safety audits
- Performance by language, age, and payer

Calls made is activity. Visits kept is closure.



Prediction without an execution path is just another dashboard



PREDICTIVE

EMERGING

Progression risk → prevention workflow

e.g., cardio-kidney-metabolic — validate before relying on it

PROACTIVE

Rising risk → care-manager queue

Requires prioritization and routing

REACTIVE

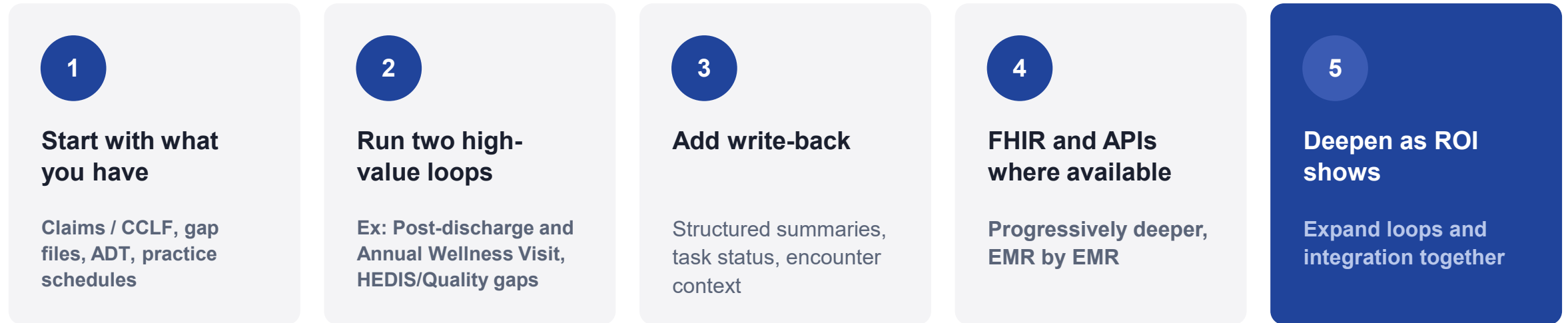
Discharge → outreach

Live in most ACOs today



Don't wait for perfect integration. Sequence it.

The operating model must create value while integration depth improves



REALITY CHECK

- Many ACOs run more than ten EHRs across participant practices
- CY2027 proposal: CEHRT options include FHIR API use and bi-directional HIE participation
- Ambulatory EMRs connect in weeks; enterprise EMRs in months
- FHIR-based digital quality reporting proposed to phase in from 2028, mandatory 2030

Start where value is clear. Standardize the workflow first. Integrate deeper as adoption and ROI become visible.

Poll 3

Answer one or more choices.



What is the biggest barrier to building an operating layer in your ACO?



Data and EMR integration



Provider and staff adoption, trust



Governance and compliance



Proving ROI



Where is your ACO today?

A four-level maturity model for AI-enabled execution

1

Manual operations

Call lists, spreadsheets, ad hoc follow-up, fragmented reporting

2

Automated workflows

Point automation — reminders, campaigns — still fragmented; activity metrics

3

THE GOAL

Connected operating layer

Shared backbone, write-back, closure KPIs, governance in place

4

Predictive operations

Risk-based prioritization, next-best workflow, learning loop

Three tests: a written closure definition · results that land in the EMR · a weekly stage-conversion review



Start with two-three loops. Earn the right to expand.

A twelve-month sequence with exit criteria — one operating layer, many workflows

PHASE 1 · FIRST 90 DAYS

Prove two loops

- Post-discharge (TCM) and Annual Wellness Visit
- Write the closure definitions
- Baseline the scorecard
- Charter governance: committee, tiers, escalation protocol

Exit: both loops live with write-back and a weekly review

PHASE 2 · MONTHS 3–6

Expand the loop

- Quality-gap loops for APP Plus measures
- After-hours access
- Deeper write-back
- Scorecard published to leadership

Exit: stage conversion improving; escalations within target

PHASE 3 · MONTHS 6–12

Connect the visit

- Pre-visit brief and ambient documentation
- HCC capture workflow
- Prediction-driven prioritization — where validated

Exit: outcome measures moving; monitoring in steady state

Design principle: one operating layer, many workflows.



How Zynix maps to the operating layer

For reference — the same architecture, with what is live today and what is still being validated

Data foundation	Zynix Data Platform — claims/CCLF, EMRs (30+ vendors), ADT, labs, HIE/C-CDA	LIVE
Intelligence	ZynixLLM and analytics — gap logic, HCC suspecting, risk stratification	LIVE
Orchestration & execution	AI agents — post-discharge/TCM, AWV, care-gap, after-hours and inbound	LIVE
Provider-facing	ZynScribe ambient documentation (Epic, athenahealth) · Pre-visit brief	LIVE / CONFIGURABLE
Care management	Care Management Portal — queues, tasks, escalations, write-back	LIVE
Prediction	Cardio-kidney-metabolic progression intelligence → prevention workflow	In Validation
Governance	SOC 2 Type II · HIPAA with BAA · role-based access · audit trails · human escalation	LIVE

Live = in production with customers today · Configurable = available, set up per deployment · In validation = being tested; not yet relied upon



Three things to take back to your ACO

01

Define closure, not activity.

For every workflow, write what "done" means before you automate anything.

02

Build the backbone once. Reuse it everywhere.

One loop — trigger, prioritize, engage, route, write back, measure — across post-discharge, AWV, quality gaps, HCC, access, and the visit.

03

Keep humans in the loop by design — and govern it like a clinical program.

Tiered autonomy, escalation with response targets, risk-based monitoring, disclosure, audit.

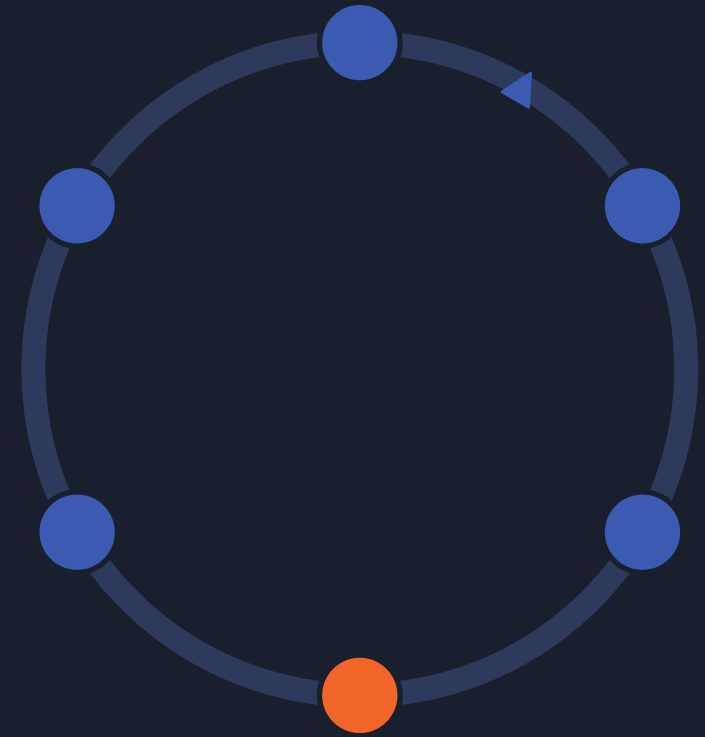


Thank you -- Q&A

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NAACOS Fall 2026 · October 14–16

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